		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0009258

Facility Name: Good Samaritan Home

Address: 2130 Harrison Street (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: (217) 223-8717 **Fax #** (217) 223-6015

IDPA ID Number: 370724112001

Date of Initial License for Current Owners: 2/22/1957

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Ms. Judy M. Graham **Telephone Number:** (217) 223-8717
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2002 to 09/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mr. Michael Duffy
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax #

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	132	48,180	3
4		Intermediate/DD			4
5	97	Sheltered Care (SC)	97	35,405	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,953	2,901	2,750	7,604	8
9	SNF/PED					9
10	ICF	21,364	60,562		81,926	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,317	63,463	2,750	89,530	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.20%

D. How many bed-hold days during this year were paid by Public Aid?
289 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy - Pool Exercise Classes

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/22/57

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 8 and days of care provided 2,701

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/2003 Fiscal Year: 09/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	807,072	39,730	17,372	864,174		864,174		864,174			1
2	Food Purchase		639,191		639,191		639,191	(13,683)	625,508			2
3	Housekeeping	245,804	39,593	19,044	304,441		304,441	(4,625)	299,816			3
4	Laundry	118,494		18,182	136,676		136,676		136,676			4
5	Heat and Other Utilities			353,345	353,345		353,345		353,345			5
6	Maintenance	237,569	44,463	89,520	371,552		371,552	4,182	375,734			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,408,939	762,977	497,463	2,669,379		2,669,379	(14,126)	2,655,253			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	3,931,149	263,270	24,385	4,218,804		4,218,804		4,218,804			10
10a	Therapy	161,311	4,091	64,998	230,400		230,400		230,400			10a
11	Activities	130,088	1,770	11,619	143,477		143,477		143,477			11
12	Social Services	126,527	644	1,827	128,998		128,998		128,998			12
13	Nurse Aide Training	23,264		2,059	25,323		25,323		25,323			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,372,339	269,775	108,488	4,750,602		4,750,602		4,750,602			16
	C. General Administration											
17	Administrative	164,412			164,412		164,412		164,412			17
18	Directors Fees											18
19	Professional Services			33,315	33,315		33,315	(514)	32,801			19
20	Dues, Fees, Subscriptions & Promotions			54,432	54,432		54,432	(8,151)	46,281			20
21	Clerical & General Office Expenses	366,125	34,847	67,733	468,705		468,705	(25,501)	443,204			21
22	Employee Benefits & Payroll Taxes			1,187,963	1,187,963		1,187,963		1,187,963			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,237	11,237		11,237	(1,017)	10,220			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			168,341	168,341		168,341		168,341			26
27	Other (specify):*											27
28	**TOTAL General Administration**	530,537	34,847	1,523,021	2,088,405		2,088,405	(35,183)	2,053,222			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,311,815	1,067,599	2,128,972	9,508,386		9,508,386	(49,309)	9,459,077			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.
**** See schedule of adjustment attached at end of cost report.**

Facility Name & ID Number Good Samaritan Home #0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			843,087	843,087		843,087	(388,057)	455,030			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			843,087	843,087		843,087	(388,057)	455,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,223		55,223		55,223		55,223			39
40	Barber and Beauty Shops	46,903	3,727	1,016	51,646		51,646		51,646			40
41	Coffee and Gift Shops	20,546	30,677	50	51,273		51,273		51,273			41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify):* Nonallowable Costs	59,392		796,560	855,952		855,952	(855,952)				43
44	**TOTAL Special Cost Centers**	126,841	89,627	895,081	1,111,549		1,111,549	(855,952)	255,597			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,438,656	1,157,226	3,867,140	11,463,022		11,463,022	(1,293,318)	10,169,704			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,683)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(92)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,841)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,964)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attach Sch 5A	(1,257,738)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,293,318)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,293,318)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Good Samaritan Home
0009258
09/30/2003

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Out of period legal fees	(264)	19
Out of period Facility License Expense	(7,500)	21
To disallow Chamber of Commerce and Kiwanis Club dues	(651)	20
To disallow Rotary & Kiwanis Club dues	(528)	21
To disallow out of state travel	(398)	24
To record this year expense on Computer Contracts	8,898	21
To record deferred Maintenance Expense for year	4,182	6
To disallow radio station expense	(638)	43
To disallow X-Ray expense	(994)	43
To disallow Lab expense	(3,980)	43
To disallow investment consultants	(198,492)	43
To disallow out of period seminar cost	(889)	24
To record last year out of period cost for seminars that related to this ye	270	24
To offset guest room income	(1,657)	30
To disallow the write-off architectural and engineering fees	(386,308)	30
To disallow cottage service income	(4,625)	3
To offset miscellaneous income	(848)	21
To offset discount earned income	(529)	21
To disallow Property Taxes	(117,007)	43
To disallow rental property expenses	(7,273)	43
To disallow radio station depreciation	(9)	43
To disallow cottage expenses	(505,754)	43
To disallow Development expense	(250)	19
To disallow Public Relation Wages	(32,494)	21
Total	**(1,257,738)**	

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/01/2002

Ending: 09/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/2002 **Ending:** 09/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,683)	0	0	0	0	0	0	0	0	0	0	(13,683)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,683)	0	0	0	0	0	0	0	0	0	0	(13,683)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,683)	0	0	0	0	0	0	0	0	0	0	(13,683)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/2002 **Ending:** 09/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(92)	0	0	0	0	0	0	0	0	0	0	(92)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(92)	0	0	0	0	0	0	0	0	0	0	(92)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(21,805)	0	0	0	0	0	0	0	0	0	0	(21,805)	43
44	**TOTAL Special Cost Centers**	(21,805)	0	0	0	0	0	0	0	0	0	0	(21,805)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(35,580)	0	0	0	0	0	0	0	0	0	0	(35,580)	45

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V				N/A				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 9/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		N/A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 169,463 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Residential Cottage Apartments 160 units for 174,278 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	1,219,680	1956-1999	$ 128,278	1
2					2
3	TOTALS	1,219,680		$ 128,278	3

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30			1957	$ 358,309	$	40	$	$	$ 358,309	4
5	75			1962	683,823		40			683,823	5
6	99			1973	1,683,761	42,094	40	42,094		1,257,923	6
7	75			1984	1,953,541	48,839	40	48,839		956,425	7
8											8
	Improvement Type**										
9	Building Service Equipment			1973	38,904		20			38,904	9
10	Land Improvements			1974	26,525	43	30	43		26,495	10
11	Building Improvements			1974	89,670	1,012	30	1,012		89,082	11
12	Building Improvements			1975	28,553		20			28,553	12
13	Building Improvements			1976	9,414		20			9,414	13
14	Building Improvements			1977	3,107		20			3,107	14
15	Building Service Equipment			1978	5,714		15			5,714	15
16	Building Improvements			1979	179		20			179	16
17	Building Service Equipment			1979	9,188		Various			9,188	17
18	Building Service Equipment			1980	1,596		Various			1,596	18
19	Building Improvements			1982	151,081	4,556	Various	4,556		112,734	19
20	Building Service Equipment			1982	17,350		Various			17,350	20
21	Building Service Equipment			1983	10,058	418	20	418		10,058	21
22	Land Improvements			1984	49,187		15			49,187	22
23	Building Service Equipment			1984	816,496	17,182	Various	17,182		805,088	23
24	Land Improvements			1985	29,707	1,355	20	1,355		26,768	24
25	Building Improvements			1985	250,935	6,273	40	6,273		114,595	25
26	Building Service Equipment			1985	184,917	8,643	Various	8,643		171,275	26
27	Land Improvements			1986	72,453	3,430	20	3,430		63,596	27
28	Building Improvements			1986	161,531	4,038	40	4,038		69,558	28
29	Building Service Equipment			1986	137,391	6,241	Various	6,241		107,814	29
30	Building Improvements			1987	19,089	500	Various	500		7,964	30
31	Building Service Equipment			1987	21,221	1,061	20	1,061		17,325	31
32	Land Improvements			1988	19,174	891	20	891		14,722	32
33	Building Service Equipment			1988	14,400	463	Various	463		13,991	33
34	Building Improvements			1989	174,123	4,758	Various	4,758		108,348	34
35	Building Service Equipment			1989	6,469	225	Various	225		6,357	35
36	Garage Additions			1990	78,563	2,619	30	2,619		35,790	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Roof - North Wing	1990	$ 43,980	$ 2,199	20	$ 2,199	$	$ 29,503	37
38	Phones	1990	600		10			600	38
39	Hall Renovations	1991	20,616	1,031	20	1,031		12,971	39
40	Building Improvements State Audit Adjustments 10881+30372	1991	511,992	18,441	30	17,066	(1,375)	210,428	40
41	Ceiling/partitions	1991	37,276	1,243	30	1,243		15,326	41
42	Office Entrance	1991	14,768	738	20	738		9,598	42
43	Building Services Equipment State Aduit Adjustment of 35	1991	83,893	1,465	various	1,441	(24)	80,793	43
44	Parking Lot	1992	4,257	213	20	213		2,128	44
45	Building Services Equipment	1992	2,706	271	10	271		2,707	45
46	Parking Lot	1992	46,071	2,304	20	2,304		24,380	46
47	Kitchen/Dining Room	1993	310,412	7,760	40	7,760		80,189	47
48	Building Services Equipment	1993	20,910	383	various	383		17,366	48
49	Parking Lot	1994	87,827	5,855	15	5,855		57,087	49
50	Manhole/Sewer	1994	2,859	191	15	191		1,843	50
51	Sidewalk	1994	7,875	525	15	525		4,769	51
52	West Nursing	1994	66,876	3,344	20	3,344		30,095	52
53	Dining Room	1994	6,990	384	various	384		3,804	53
54	Building Services Equipment	1994	134,323	5,768	various	5,768		103,980	54
55	West Nursing	1995	128,327	6,416	20	6,416		55,073	55
56	West Nursing	1995	3,151	158	20	158		1,182	56
57	Building Services Equipment	1995	22,482	1,469	various	1,469		16,285	57
58	Gas Line	1996	3,062	153	20	153		1,148	58
59	Gutters	1996	10,817	541	20	541		4,057	59
60	Eber Wing Improvements	1996	20,335	1,017	20	1,017		7,626	60
61	Roof	1996	9,016	451	20	451		3,381	61
62	Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		24,485	62
63	Building Services Equipment	1996	46,663	2,950	various	2,950		22,127	63
64	Lights/Front Land Improvements	1997	5,360	357	15	357		2,411	64
65	Walls/Floor - Anna Brown Wing	1997	41,780	2,089	20	2,089		13,579	65
66	Freezer Floor	1997	4,394	258	17	258		1,808	66
67	Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		7,316	67
68	Sprinkling System	1997	3,354	335	10	335		1,845	68
69	Tamper Detectors	1997	2,818	282	10	282		1,550	69
70	TOTAL (lines 4 thru 69)		$ 8,931,759	$ 228,022		$ 226,623	$ (1,399)	$ 6,072,672	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,931,759	$ 228,022		$ 226,623	$ (1,399)	$ 6,072,672	1
2	Compressor - Eber	1997	2,039	136	15	136		861	2
3	Compressor - East	1997	11,808	787	15	787		4,920	3
4	Sprinkler System	1997	102,875	5,144	20	5,144		31,292	4
5	Air Exchange -Pool Area State Audit adjustment 480	1997	8,092	572	15	539	(33)	3,369	5
6	Roof- Kitchen/Dinning	1998	45,550	1,168	39	1,168		6,712	6
7	Elevator Doors Dietary	1998	1,095	109	10	109		602	7
8	Underground Tanks	1998	23,092	2,309	10	2,309		12,700	8
9	Remodeling -Anna Brow Wing Walls, Celing, Floors,Lights	1999	199,131	4,978	39	4,978		20,950	9
10	Remodeling -Anna Brow Wing - Duct Detectors	1999	1,444	289	5	289		1,300	10
11	Remodeling -Anna Brow Wing - Carpeting	1999	2,966	297	10	297		1,335	11
12	Remodeling -Anna Brow Wing - Fire Damper	1999	21,915	548	39	548		2,397	12
13	Chapel Roof	1999	21,515	538	39	538		2,622	13
14	Fire Damper Alarm	1999	5,490	1,098	5	1,098		4,941	14
15	Eber Parking Lot Lights	1999	5,495	366	15	366		1,648	15
16	Lawn	1999	661	132	5	132		594	16
17	Stainless Steel D/W Exhaust	1999	1,659	166	10	166		747	17
18	Wiring Chapel Roof	1999	332	33	10	33		149	18
19	HVAC Chapel	1999	23,760	1,584	15	1,584		7,128	19
20	Code Alert System	1999	61,985	12,397	5	12,397		55,786	20
21	Elevator Upgrade A/B East	1999	22,556	2,256	10	2,256		10,151	21
22	Elevator Upgrade - Special Care	1999	5,970	597	10	597		2,687	22
23	Fire Protection A/B	1999	4,500	450	10	450		2,025	23
24	Condensor Unit	1999	22,945	1,530	15	1,530		6,884	24
25	Fire Proctection Pool Area	1999	776	78	10	78		350	25
26	Damper Duct Work	1999	5,602	373	15	373		1,680	26
27	Lighting- Special Care	1999	2,075	138	15	138		622	27
28	Chapel Remodeling - Fire Damper	2000	3,196	213	15	213		746	28
29	Chapel Remodeling - Sign	2000	77	16	5	16		54	29
30	Chapel Remodeling - Painting	2000	4,751	119	39	119		362	30
31	Chapel Remodeling - Carpeting	2000	3,073	205	15	205		717	31
32	Chapel Remodeling - Unity & Pews	2000	14,760	369	39	369		1,122	32
33	Kitchen Remodeling - Hood	2000	2,511	167	15	167		585	33
34	TOTAL (lines 1 thru 33)		$ 9,565,455	$ 267,184		$ 265,752	$ (1,432)	$ 6,260,710	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,565,455	$ 267,184		$ 265,752	$ (1,432)	$ 6,260,710	1
2	Kitchen Remodeling - Sky Roof Flashing	2000	3,086	206	15	206		721	2
3	Kitchen Remodeling - Sidewalls	2000	3,485	232	15	232		813	3
4	Kitchen Remodeling - Galvanized Wall Divider	2000	2,601	173	15	173		606	4
5	East Nursing Remodeling - Walls, Ceilings, Floors	2000	26,757	669	39	669		2,202	5
6	Eber Wing Smoke Damper	2000	16,485	1,099	15	1,099		3,847	6
7	Special Care Lighting	2000	14,290	953	15	953		3,335	7
8	HVAC Rehab Eber Wing	2000	305,419	20,361	15	20,361		71,264	8
9	Groundkeeper	2000	5,298	757	7	757		2,649	9
10	3 Ton Rooftop Unit A/C West Dining	2000	2,776	185	15	185		648	10
11	Telephone Unit	2000	323	46	7	46		161	11
12	Elevator Up Grade East Wing	2000	12,776	852	15	852		2,982	12
13	Superior Boiler Burner Up Grade	2000	1,101	73	15	73		256	13
14	Entrance Codelock Special Care	2000	1,848	123	15	123		431	14
15	Life Safety Code Sprinkler Drains	2000	7,000	467	15	467		1,634	15
16	Land Improvement New Sidewalk	2000	1,200	60	20	60		150	16
17	Renovation of East nursing Wing	2001	369,213	9,230	39	9,230		20,383	17
18	Exterior Painting	2001	14,347	956	15	956		2,390	18
19	Painting Kitchen	2001	2,550	170	15	170		425	19
20	Chapel Renovation	2000	2,001	50	39	50		144	20
21	Kitchen Electrical Work	2000	611	41	15	41		102	21
22	HVAC Rehab Eber Wing	2000	5,584	372	15	372		930	22
23	Sprinklers	2000	4,151	277	15	277		692	23
24	Wet Chemical Fire Suppressor Work	2000	3,695	246	15	246		615	24
25	Electrical Work	2001	1,609	107	15	107		268	25
26	Smoke/ Fire Damper East, South and Eber	2001	50,735	3,382	15	3,382		8,455	26
27	Air Compressor Anna Brown Wing	2001	10,911	728	15	728		1,819	27
28	3D Detectors in Elevators	2001	4,916	492	10	492		738	28
29	Exhaust fan	2001	1,815	181	10	181		272	29
30	Compensators	2001	2,724	272	10	272		408	30
31	33 Lever Passage Locks	2002	2,904	290	10	290		435	31
32	Exit Lights and Hold Opens	2002	966	96	10	96		144	32
33	16 Lever Passage Locks	2002	1,408	141	10	141		211	33
34	TOTAL (lines 1 thru 33)		$ 10,450,040	$ 310,471		$ 309,039	$ (1,432)	$ 6,390,840	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,450,040	$ 310,471		$ 309,039	$ (1,432)	$ 6,390,840	1
2	48 Lockouts	2002	985	99	10	99		148	2
3	Water Piping	2001	4,600	115	39	115		216	3
4	New Curb & Driveway	2002	16,118	806	20	806		1,209	4
5	Buffet in Dining Area	2003	2,977	135	15	135		135	5
6	Door - code alert and keypad	2003	2,489	166	10	166		166	6
7	Fire Collars	2003	3,619	224	10	224		224	7
8	Kitchen Exhaust Fans	2003	2,663	44	10	44		44	8
9	Main Breaker	2003	3,291	18	15	18		18	9
10	Elevator Master Door Operator	2003	4,278	178	10	178		178	10
11	Training Room Drainage	2003	731	9	39	9		9	11
12	Dietary - Floor Drain	2003	223	2	39	2		2	12
13	Handicap Accessible Entrance and Sidewalk	2003	3,200		20				13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	Write- off of architectural an engineering fees from prior yrs.			386,308			(386,308)		30
31									31
32	Guest Room Income Offset					(1,657)	(1,657)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,495,214	$ 698,575		$ 309,178	$ (389,397)	$ 6,393,189	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,059,418	$ 113,345	$ 114,685	$ 1,340	20-3 yrs	$ 725,453	71
72	Current Year Purchases	327,508	17,762	17,762		10-5 yrs	17,762	72
73	Fully Depreciated Assets	1,268,501				20-3 yrs	1,268,501	73
74								74
75	TOTALS	$ 2,655,427	$ 131,107	$ 132,447	$ 1,340		$ 2,011,716	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident	Various	Various	$ 97,782	$ 8,837	$ 8,837	$	3-5 yrs	$ 85,079	76
77	Maintenance	Various	Various	73,691	2,187	2,187		3-5 yrs	72,590	77
78	Maintenance	Various	Various	1,219				3	1,219	78
79	See Attach Sch 13A	Various	2002	15,472	2,381	2,381		5 yrs	3,214	79
80	TOTALS			$ 188,164	$ 13,405	$ 13,405	$		$ 162,102	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	13,467,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	843,087	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	455,030	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(388,057)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	8,567,007	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage Land	$ 76,532	$	$	86
87	Rental Property Land	75,730			87
88	Cottage Fixed Assets	8,128,253	233,203	4,321,808	88
89	Rental Property Fixed Assets	219,235	7,273	39,012	89
90	Radio Station	14,161	9	14,038	90
91	TOTALS	$ 8,513,911	$ 240,485	$ 4,374,858	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$	$	$	$ 0		$	37
38	Current Year Purchases				0			38
39	Fully Depreciated Assets				0			39
40					0			40
41	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	Toro 2001	2001	$ 825	$ 165	$ 165	$ 0	5 yrs	$ 248	42
43	Maintenance	Chevy S-10 98	2002	7,508	1,502	1,502	0	5 yrs	2,252	43
44	Facility	Toro mower	2003	7,139	714	714	0	5 yrs	714	44
45							0			45
46	TOTALS			$ 15,472	$ 2,381	$ 2,381	$ 0		$ 3,214	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions		N/A					4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ N/A
13.	/2005	$ N/A
14.	/2006	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18		N/A			18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 240	$	$ 240
2	Books and Supplies	95	924		1,019
3	Classroom Wages (a)	682	9,374		10,056
4	Clinical Wages (b)		5,028		5,028
5	In-House Trainer Wages (c)		8,180		8,180
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		800		800
9	TOTALS	$ 777	$ 24,546	$	$ 25,323
10	SUM OF line 9, col. 1 and 2 (e)	$ 25,323			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	18

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L. 10a C1, 2,3	1239 hrs	$ 22,902	605	$ 29,817	$ 415	1,844	$ 53,134	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		225	11,659		225	11,659	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 1,2,3	5513 hrs	138,409	608	23,522	3,676	6,121	165,607	4
5	Physician Care		visits							5
6	Dental Care	L.10 C 2, 3	visits		12	2,400	659	12	3,059	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39 C 2	# of prescrpts				55,223		55,223	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 161,311	1,450	$ 67,398	$ 59,973	8,202	$ 288,682	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 407,358	$ 407,358	1
2	Cash-Patient Deposits	24,306	24,306	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	526,826	526,826	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,165,228	1,165,228	5
6	Prepaid Insurance	201,521	201,521	6
7	Other Prepaid Expenses	6,734	14,234	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,331,973	$ 2,339,473	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	23,878,141	23,878,141	12
13	Land	128,278	128,278	13
14	Buildings, at Historical Cost	10,745,925	10,495,214	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,836,892	2,843,591	16
17	Accumulated Depreciation (book methods)	(8,789,804)	(8,567,007)	17
18	Deferred Charges		2,091	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe			22
23	Other(specify): Cottage & Rental Property	4,139,053	4,139,053	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 32,938,485	$ 32,919,361	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 35,270,458	$ 35,258,834	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 328,565	$ 328,565	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,306	24,306	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	632,784	632,784	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,484	21,484	31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,927		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Sch 17C	57,098	57,098	36
37	Prepaid Residents Rent	362,416	362,416	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,512,580	$ 1,426,653	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,512,580	$ 1,426,653	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 33,757,878	$ 33,832,181	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 35,270,458	$ 35,258,834	48

***(See instructions.)**

Good Samaritan Home
0009258
09/30/2003

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Wage Assignments Payable	133	133
Accrued United Way	114	114
Employee Assist Fund Withheld	8,730	8,730
Benevolent Fund Payable	1,066	1,066
Flower Fund Payable	(3,376)	(3,376)
Ceramics Payable	1,550	1,550
Application Fee Payable	29,580	29,580
Medicare Liability	13,017	13,017
F.W. Education Cost Payable	6,284	6,284
Total Line 36 - Other Current Liabilities(specify):	**57,098**	**57,098**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 31,856,676	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 31,856,676	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,901,201	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,901,201	17
	B. Transfers (Itemize):		
18	**Rounding error**	1	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 33,757,878	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,997,654	1
2	Discounts and Allowances for all Levels	(994,655)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,002,999	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	525,511	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 525,511	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	34,704	12
13	Barber and Beauty Care	61,282	13
14	Non-Patient Meals	13,683	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	104,407	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,899	19
20	Radiology and X-Ray	2,050	20
21	Other Medical Services	64,178	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 288,203	23
	D. Non-Operating Revenue		
24	Contributions	442,277	24
25	Interest and Other Investment Income***	2,872,467	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,314,744	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attach Schedule 19E	33,654	28
28a	Cottage and Reantal Property Income	1,199,112	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,232,766	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,364,223	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,669,379	31
32	Health Care	4,750,602	32
33	General Administration	2,088,405	33
	B. Capital Expense		
34	Ownership	843,087	34
	C. Ancillary Expense		
35	Special Cost Centers	1,014,094	35
36	Provider Participation Fee	97,455	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,463,022	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,901,201	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,901,201	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Good Samaritan Home
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Schedule 19E

XVII. INCOME STATEMENT

Revenue

E. Other Revenue (specify):	Amount
Miscellaneous Income	848
Discount Earned Income	529
Guest Room Income	1,657
Van Transportation	21,670
Cottage Services Income	4,625
Application Fee Income	4,325
Total Line 28 - Other Revenue (specify):	**33,654**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,931	2,080	$ 57,014	$ 27.41	1
2	Assistant Director of Nursing	1,952	2,080	39,263	18.88	2
3	Registered Nurses	26,880	29,475	501,736	17.02	3
4	Licensed Practical Nurses	62,881	68,335	967,179	14.15	4
5	Nurse Aides & Orderlies	192,986	209,077	2,073,877	9.92	5
6	Nurse Aide Trainees	2,228	2,228	15,083	6.77	6
7	Licensed Therapist	6,636	6,752	161,311	23.89	7
8	Rehab/Therapy Aides	11,536	12,864	145,194	11.29	8
9	Activity Director	1,968	2,080	23,327	11.21	9
10	Activity Assistants	12,340	13,267	106,761	8.05	10
11	Social Service Workers	13,373	14,326	126,527	8.83	11
12	Dietician					12
13	Food Service Supervisor	7,690	8,493	122,949	14.48	13
14	Head Cook	7,006	7,549	75,306	9.98	14
15	Cook Helpers/Assistants	56,117	60,571	515,174	8.51	15
16	Dishwashers	10,664	11,337	93,643	8.26	16
17	Maintenance Workers	22,841	24,696	237,569	9.62	17
18	Housekeepers	26,240	28,791	245,804	8.54	18
19	Laundry	11,896	13,185	118,494	8.99	19
20	Administrator	1,932	2,080	92,894	44.66	20
21	Assistant Administrator	1,892	2,080	71,518	34.38	21
22	Other Administrative	7,872	8,340	129,908	15.58	22
23	Office Manager					23
24	Clerical	18,470	20,240	236,217	11.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,989	2,149	30,780	14.32	31
32	Other Health Ca Sch 20A	11,218	12,561	124,287	9.89	32
33	Other(specify) Sch 20A	12,660	13,671	126,841	9.28	33
34	TOTAL (lines 1 - 33)	533,198	578,307	$ 6,438,656 *	$ 11.13	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	475	$ 15,001	L 1 C3	35
36	Medical Director	Monthly	3,600	L 9 C3	36
37	Medical Records Consultant	Monthly	1,740	L 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,044	L 10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	69	2,029	L 11 C3	44
45	Social Service Consultant	8	1,827	L 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	552	$ 34,241		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Good Samaritan Home
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Schedule 20A

XVIII. STAFFING AND SALARY COSTS
LINE 32 - Other (Health Care specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Nurse Aide Instructor	446	446	$ 8,181	18.34
Nursing Secretary	7,515	8,432	$ 77,284	9.17
Medical Supply Clerk	1,972	2,205	20,214	9.17
Staff Coord.	1,285	1,478	18,608	12.59
Total Line 32 - Other	**11,218**	**12,561**	**$ 124,287**	**$ 9.89**

XVIII. STAFFING AND SALARY COSTS
LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Maintenance Cottages	5,710	6,174	$ 59,392	9.62
Beauty Shop	4,454	4,856	46,903	9.66
General Store	2,496	2,641	20,546	7.78
Total Line 33 - Other	**12,660**	**13,671**	**$ 126,841**	**$ 9.28**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Duffy	Administrator	0	$ 92,894
Judy Graham	Asst Admin.	0	71,518
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 164,412

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Keyl Royster Voelker & Allen	Legal	$ 4,518
Schmiedeskamp, Robertson	Legal	8,522
Neu & Mitchell		
Wade Stables PC	Accounting	15,650
Bureau of Citizens &	Filing Fee for Jerry Klukowski	4,375
Information Services	for Immigration	
Rodemich Appraisal	Appraisal	250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,315

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 132,139
Unemployment Compensation Insurance	2,208
FICA Taxes	470,214
Employee Health Insurance	391,498
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Tuition	(282)
Pension Plan	160,882
Employee Medical	17,219
Life Insurance	3,698
Employee Recognition	10,387
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,187,963

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	20,415
Health Care Worker Background Check	
(Indicate # of checks performed 77)	911
Life Services Network	15,354
Council for Health and Human Services	7,455
Various Dues, Licenses, and Permits	2,146
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,281

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached Schedule	10,220
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,220

**See instructions.

Good Samaritan Home
Provider #: 0009258
10/01/2002 to 09/30/2003

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	33,315
Legal fees out of period	(264)
Development Cost for Cottages	(250)
Total (agree to Schedule V, line 19, column 8)	32,801

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Elevator Repairs	Jan 2001	$ 6,737	3	$	$ 1,123	$ 2,246	$ 2,246	$ 1,122	$	$	$	$
2	Water Heater Repair	Dec 2000	1,311	3		218	437	437	219				
3	Kitchen Garbage Disp.	Apr 2001	4,498	3		750	1,499	1,499	750				
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$ 12,546		$	$ 2,091	$ 4,182	$ 4,182	$ 2,091	$	$	$	$

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $15,354 CHHS $7,455**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8.17**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **85,908** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **97,455**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **Yes** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **13,683**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wade Stables P. C.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	807,072	39,730	17,372	864,174	0	864,174	0	864,174
2. Food Purchase	0	639,191	0	639,191	0	639,191	-13,683	625,508
3. Housekeeping	245,804	39,593	19,044	304,441	0	304,441	-4,625	299,816
4. Laundry	118,494	0	18,182	136,676	0	136,676	0	136,676
5. Heat and Other Utilities	0	0	353,345	353,345	0	353,345	0	353,345
6. Maintenance	237,569	44,463	89,520	371,552	0	371,552	4,182	375,734
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,408,939	762,977	497,463	2,669,379	0	2,669,379	-14,126	2,655,253
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	3,931,149	263,270	24,385	4,218,804	0	4,218,804	0	4,218,804
10a. Therapy	161,311	4,091	64,998	230,400	0	230,400	0	230,400
11. Activities	130,088	1,770	11,619	143,477	0	143,477	0	143,477
12. Social Services	126,527	644	1,827	128,998	0	128,998	0	128,998
13. Nurse Aide Training	23,264	0	2,059	25,323	0	25,323	0	25,323
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,372,339	269,775	108,488	4,750,602	0	4,750,602	0	4,750,602
17. Administrative	164,412	0	0	164,412	0	164,412	0	164,412
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	33,315	33,315	0	33,315	-514	32,801
20. Fees, Subscriptions & Promotion	0	0	54,432	54,432	0	54,432	-8,151	46,281
21. Clerical & General Office	366,125	34,847	67,733	468,705	0	468,705	-25,501	443,204
22. Employee Benefits & Payroll	0	0	1,187,963	1,187,963	0	1,187,963	0	1,187,963
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	11,237	11,237	0	11,237	-1,017	10,220
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	168,341	168,341	0	168,341	0	168,341
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	530,537	34,847	1,523,021	2,088,405	0	2,088,405	-35,183	2,053,222
29. Total General Administrative	6,311,815	1,067,599	2,128,972	9,508,386	0	9,508,386	-49,309	9,459,077
30. Depreciation	0	0	843,087	843,087	0	843,087	-388,057	455,030
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	843,087	843,087	0	843,087	-388,057	455,030
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	55,223	0	55,223	0	55,223	0	55,223
40. Barber and Beauty Shop	46,903	3,727	1,016	51,646	0	51,646	0	51,646
41. Coffee and Gift Shops	20,546	30,677	50	51,273	0	51,273	0	51,273
42	0	0	97,455	97,455	0	97,455	0	97,455
43. Other (specify):*	59,392	0	796,560	855,952	0	855,952	-855,952	0
44. Total Special Cost Ce	126,841	89,627	895,081	1,111,549	0	1,111,549	-855,952	255,597
45. Grand Total	6,438,656	1,157,226	3,867,140	11,463,022	0	11,463,022	-1,293,318	10,169,704

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	407,358	407,358
2. Cash - Patient Deposits	24,306	24,306
3. Accounts & Notes Recievable	526,826	526,826
4. Supply Inventory	0	0
5. Short-Term Investments	1,165,228	1,165,228
6. Prepaid Insurance	201,521	201,521
7. Other Prepaid Expenses	6,734	14,234
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,331,973	2,339,473
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	23,878,141	23,878,141
13. Land	128,278	128,278
14. Buildings, at Historical Cost	10,745,925	10,495,214
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,836,892	2,843,591
17. Accumulated Depreciation (book methods)	-8,789,804	-8,567,007
18. Deferred Charges	0	2,091
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	4,139,053	4,139,053
24. Total Long-Term Assets	32,938,485	32,919,361
25. Total Assets	35,270,458	35,258,834
CURRENT LIABILITIES		
26. Accounts Payable	328,565	328,565
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	24,306	24,306
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	632,784	632,784
31. Accrued Taxes Payable	21,484	21,484
32. Accrued Real Estate Taxes	85,927	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	57,098	57,098
37. Other Current Liabilities (specify):	362,416	362,416
38. Total Current Liabilities	1,512,580	1,426,653
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	1,512,580	1,426,653
47.Total Equity	33,757,878	33,832,181
48.Total Liabilities and Equity	35,270,458	35,258,834

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,997,654
2. Discounts and Allowances for all Levels	-994,655
Subtotal - Inpatient Care	8,002,999
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	525,511
7. Oxygen	0
Subtotal - Anciliary Revenue	525,511
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	34,704
13. Barber and Beauty Care	61,282
14. Non-Patient Meals	13,683
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	104,407
18. Sale of Supplies to Non-Patients	0
19. Laboratory	7,899
20. Radiologyand X-Ray	2,050
21. Other Medical Services	64,178
22. Laundry	0
Subtotal - Other Operating Revenue	288,203
24. Contributions	442,277
25. Interest and Other Investments Income	2,872,467
Subtotal - Non-Operating Revenue	3,314,744
27. Other Revenue (specify):	33,654
28. Other Revenue (specify):	1,199,112
Subtotal - Other Revenue	1,232,766
30. Total Revenue	13,364,223
31. General Services	2,487,770
32. Health Care	4,583,125
33. General Administration	2,075,050
34. Ownership	478,190
35. Special Cost Centers	1,014,272
35. Provider Participation Fee	97,455
37. Other	0
40. Total Expenses	10,735,862
41. Income Before Income Taxes	2,628,361
42. Income Taxes	0
43. Net Income or Loss for the Year	2,628,361

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23	Provider Participation fee is linked from page 4